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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Feb/10/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: spinal cord stimulator trial

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Neurological Surgery

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[ ] Upheld (Agree)
[X] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is this reviewer's opinion that medical necessity for spinal cord stimulator trial is established

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who was injured on xx/xx/xx due to a lifting injury. The patient has been followed for a diagnosis of post-laminectomy syndrome in the lumbar spine as well as degenerative disc disease. The patient was followed for continuing complaints of chronic low back and leg pain through 12/15/14. The patient did have a psychological evaluation submitted for review from 02/04/13 which did recommend proceeding with a spinal cord stimulator trial. No updated psychological evaluations were submitted for review. As of 12/15/14, the patient was utilizing Hydrocodone at a rate of 3 per day. The patient was also utilizing Flexeril at night. The patient's physical examination noted an antalgic gait with a slightly flexed forward posture. There was good sensation in the lower extremities with intact strength. The patient was wishing to minimize his medication usage and increase function and a spinal cord stimulator trial was recommended at this evaluation.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The clinical documentation submitted for review provided additional information from the psychological evaluation on 02/04/13. Per the additional information, the patient was recommended as a fair candidate for a spinal cord stimulator trial. The patient was noted to be motivated for the trial during the evaluation. The clinical reports provided for review identified no significant change in the patient's psychological status that would warrant an updated psychological evaluation. The patient does have a diagnosis of post-laminectomy syndrome stemming from prior surgical procedures for the lumbar spine which is a noted indication for a spinal cord stimulator trial per guidelines. The patient wishes to reduce medication usage and has failed other conservative efforts to include injection therapy. At this point in time, the patient would meet guideline recommendations regarding the proposed spinal cord stimulator trial. Therefore, it is this reviewer's opinion that medical necessity for spinal cord stimulator trial is established at this time and the prior denials are overturned.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)